STATE OF IDAHO
DEPARTMENT OF ADMINISTRATION
OFFICE OF GROUP INSURANCE
P.O. BOX 83720 BOISE, ID 83720-0035
(208) 332-1860 OR 1-800-531-0597
ogi@adm.state.id.us

Self Pay Reporting Form

Supplemental Life

For submission to
The Office of Group Insurance
By the 5th of the Month

Agency _____ **Month** _____

LWOP ***Eligible to pay for 6 months.***

Name & Social Security No.	Reason for LWOP	LWOP Date	Certified Monthly Salary	Premium Paid
			Total premium received	

Disability *Premium due the first six months of disability*

Name & Social Security No.	Date Disabled	Certified Monthly Salary	Premium Paid
		Total premium received	
		Total premium paid	

Attach all checks to form

Rev 11/2004